
DISCUSSION PIECE

Changing Imperatives in Workforce Planning: Implications for Health and Social Care Education

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Abstract

Workforce planning forms an increasing focus within health and social care policy and structural development, with concern to ensure that workforce supply demonstrably meets demand (in terms of population, patient, service and practice needs). While particularly apparent in England, this trend can be seen elsewhere in the United Kingdom. This article considers the implications of this trend for health and social care education, including practice education. Although having a particular emphasis on challenges and opportunities for the allied health professions, the article considers the issues more generically.

Workforce planning is now seen within policy as key to addressing priority population and patient care needs; achieving service improvements while containing expenditure; and ensuring that patient needs are put first. The size, profile and skills development of the workforce is therefore being placed centre-stage in order to enhance service design and delivery, assure clinical and cost-effectiveness, and deliver compassionate care.

These developments raise both challenges and opportunities for education providers. Within curriculum design and delivery, an increasing focus is needed on developing the knowledge, skills and aptitude required for clinical leadership and inter-professional collaboration, and on evidencing the value, impact and professionalism of individual practitioners, services and professions. This is producing a related, stronger focus on how practice education prepares future members of the workforce for more flexible, diverse roles in safe, patient-centred ways. New approaches to workforce planning are creating increased opportunity for education to demonstrate how it both responds to and leads change, while affirming quality assurance imperatives.

Keywords: workforce, planning, supply, demand

Introduction

There has been an increased focus on workforce planning within health and social care policy and structural development in recent years. Workforce planning is now explicit

within proposals and strategies to ensure changing population and patient needs can be met safely and effectively within constrained financial resources. It is also at the heart of ensuring that education is developed, at all levels, to optimise its responsiveness to changing needs and its capacity to lead change. Linked to both, workforce planning has been identified as a central component in achieving a systemic, robust response to failures in the delivery of patient-centred, compassionate care. It has therefore been conferred a high priority within health and social care reform, effectively constituting a new prism through which education, skill mix, service delivery and practice and role development all need to be considered (Department of Health 2012a, 2013a and 2013b, HM Government 2012, House of Commons Health Committee 2012, Secretary of State for Health 2012, Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013, NHS Scotland 2013).

While having an inherent logic, planned new approaches are significantly different from methods that based decision-making primarily on maintaining established patterns of workforce supply, premised on the assumption that 'more of the same' is the best way of meeting future workforce demands. New approaches present significant opportunities and challenges, throwing into relief how workforce supply and demand can best be balanced and how education can meet supply requirements.

This article explores the reasons for this strengthened focus on workforce planning and considers the issues it presents for the health and social care professions. While looking at these particularly from an allied health profession (AHP) perspective and particularly within England, it takes account of developments across the United Kingdom. It should also have relevance to the health and social care professions more broadly. It identifies emergent implications for education providers and for the delivery and development of practice education.

Concepts and processes

Although a frequently used term, 'workforce planning' is not a straightforward concept. The Centre for Workforce Intelligence (CfWI) defines it as 'the process of ensuring that a business or organisation has the right number of employees, with the right knowledge, skills and behaviours in the right place, at the right time' (Centre for Workforce Intelligence 2012a). This sounds relatively simple. However, extended to apply to a multifaceted workforce – one that spans a whole health and social care economy and comprises multiple professions, disciplines, occupational roles and levels of practice – it gains a high degree of complexity.

Nor is workforce planning straightforward as a process. Its practical implementation is rendered complex by the patent impossibility of starting such planning from scratch: decision-making has to build on existing staffing models and established approaches. Achieving change also requires relatively long lead-in times, not least because the outcome of developing and delivering new education programmes takes a period of years to emerge.

The historical starting-points for addressing workforce planning across the professions are highly variable, from established arrangements for seeking to control student numbers according to perceived workforce demand to what effectively amount to 'free market' approaches. Where workforce planning processes have been in place, they have not necessarily or consistently achieved the required correlation between workforce demand and supply. This has led to supply, in certain specialties and professions, periodically exceeding or falling short of demand, with projected shortfalls now being identified in England for general practitioners and health visitors, reflecting a planned shift of more service delivery to primary care (Department of Health 2013b). Pharmacy is also a focus of

concern and review in terms of achieving a stronger correlation in England between student numbers, placement supply and workforce needs (John 2008, Gibney 2012a and 2012b, Centre for Workforce Intelligence 2013a, Department of Health 2013c).

When uncertainties, ambiguity and volatility about the nature of future demand are added in, the full challenges of pursuing workforce planning become apparent (World Health Organisation 2010, George Washington University 2013). The CfWI explains that its approach is now 'to work "back from the future". . .first think(ing) about what health and social care may look like in the future, including the workforce needed to provide it' (Centre for Workforce Intelligence 2012a and 2013b). The CfWI has therefore shifted its focus to 'horizon-scanning', seeking to formulate and use projections of future patient need within specialties and patient pathways (rather than starting with numbers for individual professions), and to apply modelling techniques to inform decision-making about workforce requirements in the immediate and medium-term (Centre for Workforce Intelligence 2012a, 2012b and 2013c).

New approaches to workforce planning are now being implemented in England by local education and training boards (LETBs), each accountable to Health Education England (East Midlands Local and Education Training Board 2013, Health Education England 2013). In turn, HEE has its strategic direction set by the Department of Health's educational outcomes framework and mandate (Department of Health 2013b and 2013c, Health Education England 2013). Parallel approaches are being taken forward elsewhere in the UK, if through different structures and with slightly different emphases (NHS Scotland 2013, NHS Wales 2013). The new challenge is for workforce planning ambitions to be realised in a context of rapid structural change, particularly within England, and changing service needs.

Why a focus on workforce planning now?

A specific focus on workforce planning, as an integral component of health and social care reform, is relatively new. Considerations of the impact of how a workforce is formed barely figured in programmes of health care reform in the UK before the 1990s (Buchan & Maynard 2006). With the scale and pace of current and projected change in health and social care, it has been identified that a significant shift can be enacted by addressing how workforce planning is undertaken to balance supply and demand. Imperatives to contain expenditure while increasing quality and the standardisation of care mean that there is no longer a tacit assumption that workforce planning can simply be a matter of ensuring the consistent supply of staff to deliver a static, unchanging set of services. Rather, workforce planning is seen as a strong agent for achieving change - to enhance quality, in the context of rising expectations, and to contain expenditure, in the context of financial constraint.

At a basic level, the scale of the health and social care workforce and the public funding involved in its creation have led to heightened concerns to achieve a sound return on investment (Universities UK 2012, Department of Health 2013c, Health Education England 2013). There is increasing concern to ensure that workforce supply – in terms of a workforce that is of the 'right' size, composition and skill set – correlates with workforce demand, such that the changing needs of population groups, patients, services and practice can evidently be met in clinically cost-effective ways. Beyond this, there is a growing recognition that existing workforce planning processes and outcomes can be improved, with real scope for innovation in how workforce planning is undertaken. This includes more rigorous approaches to the collection and analysis of the data on which workforce planning decisions are made; achieving more inclusive, lateral approaches to decision-making; and optimising opportunities to develop workforce potential through skill mix review and role

development (Department of Health 2012a, Department of Health 2013c, Health Education England 2013).

In addition, there is a recognition that while achieving an apparently simple correlation between the size of a workforce and a population is one way of deducing workforce supply needs – although this approach may not lead to the same configurations and profile of health and social care workforce in different countries – there is value in pursuing more nuanced approaches, particularly those informed by identifying projected population needs and how these can be met by developing the role profiles and relative skill sets of different professional groups (George Washington University 2013). Naturally, different questions about workforce demand generate different answers about workforce supply requirements and the education provision that can best meet these.

A range of factors is contributing to a more critical approach to determining workforce demand and supply needs (including the nature of the workforce created and *how* it is created). These include more actively seeking to address the underlying causes of need through health promotion, illness prevention and attending to the predisposing factors for ill health, rather than simply addressing the needs themselves. More specifically, there is a growing recognition of the need to address the health inequalities manifested in relative health and morbidity trends across population groups, derived from social, economic and environmental determinants (University College London Institute of Health Equity 2013). This creates a need to look at the requirements of workforce supply differently (including those relating to skill mix review, occupational and professional roles, boundaries and settings) so that health and social care interventions happen at points that optimise outcomes for individuals.

Health and social care priorities are increasingly being used to inform decision-making about the services developed and delivered, and the workforce required to generate and supply these. Across the UK, emergent priorities largely relate to addressing the rapid rise of non-communicable diseases, meeting the needs of an ageing population, and caring for patients with increasingly complex, multiple and long-term conditions. In turn, these priorities are bringing to the fore a stronger role for public health; an increasing shift to delivering services in primary care settings; and a growing focus on using new technologies to increase the reach, responsiveness and efficiency of services, including models that more strongly promote and support patient self-management and independence (Department of Health 2012a, Department of Health 2013b, Health Education England 2013, Health and Social Care Information Centre 2013).

There is also now a stronger focus on achieving care that is genuinely patient-centred, explicitly underpinned by the values of professionalism, and predicated on inter-professional collaboration. Assumptions that specific workforce needs must necessarily be met by particular professions and occupational groups have begun to be eroded, with a shift to an understanding that service delivery can be enacted by whomever has the knowledge, understanding and skills to do so safely, effectively and efficiently (with due adherence to legal and regulatory requirements). In particular, this shift has given rise to the development and use of competence frameworks, including those expressed as occupational standards, with a view to increasing workforce flexibility and responsiveness to change. While carrying risks in terms of how effectively these capture the nuances and complexities of professional activity and underpinning knowledge, engagement with initiatives relating to explicit, flexible role development across professions and groups now has raised significance. This includes demonstrating the ability of professions and individual practitioners to adapt to and influence changing models of service delivery.

The Francis Inquiry and publication of the second-stage report in February 2013 (Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013) have reinforced the underlying

imperative to deliver compassionate, value-led services across health and social care. Recommendations following the Mid-Staffordshire Inquiry centre on recalibrating the prevailing culture, such that patient safety, needs and interests are always put first. The report recognises that not all care has been delivered in this way. A range of factors – to do with lapses in organisational and individual responsibility, leadership and professionalism – has worked against consistent fulfilment of what should be the underpinning principles of service delivery (Centre for Workforce Intelligence 2013d, Department of Health 2013a, 2013b and 2013c, Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013).

The UK government's initial response to the Francis report has put workforce planning centre-stage for achieving this shift of culture, with its mandate to Health Education England (HEE) strongly focused on achieving a workforce that has the capacity, competence and commitment to deliver consistently high-standard care within which patient interests and needs rightly have pre-eminence (Department of Health 2012c, 2013b, 2013c and 2013d). Such an approach is also apparent in NHS Scotland's workforce vision (NHS Scotland 2013).

A combination of factors can therefore be seen to have created a fresh approach to workforce planning: the recognition that decisions need to be grounded in projected population trends and health and social care needs; financial constraint forcing a closer scrutiny of how expanding needs and expectations can most effectively and efficiently be met and contained; and a confidence that innovative solutions can be found to enhance the quality of service delivery and patient outcomes. However, different approaches to workforce planning are by no means straightforward: they create a range of imperatives and opportunities.

Challenges and opportunities

A more critical approach to establishing demand and meeting this through supply puts the onus on the health and social care professions, both individually and collectively, to demonstrate their value (Centre for Workforce Intelligence 2013c and 2013e). This relates to how they contribute to the quality of patient outcomes; the evidence base of their practice; their relevance to, and impact on, addressing identified health and social care priorities; and their capacity to provide innovative, cost-effective solutions to how services are delivered. This includes in ways that refine patient referrals, minimise hospital (re-)admissions and reduce length of hospital stays. From a patient perspective, there is a need to demonstrate that professions enhance individuals' experience of care and the quality of its outcomes. This includes patients having timely access to the services that can most benefit them; their receipt of integrated, individualised care packages; their experiencing care closer to home; and fulfilment of their justified expectations of receiving care that is delivered with compassion and that fully respects their dignity. These growing priorities have significant implications for how the workforce is enabled to develop.

An ever more significant imperative is ensuring that the breadth of needs across employment and service sectors is met through workforce planning. The increasing integration of services across health and social care; the expansion of services delivered through public health initiatives (including as local authorities take lead responsibility for these in England); and the growing diversity of health and social care providers (with a greater number of private and other providers delivering both NHS-funded and non-NHS-funded care) are all contributing to workforce demand becoming more complex and diffuse (Department of Health 2012a and 2012b, HM Government 2012, House of Commons Health Committee 2012, Chartered Society of Physiotherapy 2013a, King's Fund 2013).

A simple focus on NHS workforce needs, therefore, which can be seen to have predominated for many health professions in the past, risks creating an increasingly partial picture of workforce demand and therefore of producing an insufficient workforce supply (Department of Health 2012a, House of Commons Health Committee 2012). It also highlights challenges and changing needs in respect of how future members of the workforce are prepared for practice. Of increasing importance is that the workforce be enabled to develop the knowledge, skills and attributes to work across sectors and settings and within inter-professional teams, including to strengthen the integration of services and the cohesion of care packages for individual patients (King's Fund 2013). Support for the whole workforce to develop and demonstrate clinical leadership must underpin this (NHS Leadership Academy 2011).

There is a further need to secure and strengthen links between education and research, to support innovation in practice and swift knowledge transfer (Department for Business, Innovation and Skills 2011, NHS England 2013). It is imperative to nurture a workforce that is able to develop and use the knowledge and skills required to engage in evidence-informed practice and service improvement. In addition, it is vital that professions continue to be supported to access clinical academic research initiatives to sustain their collective development and use of research in practice (Department of Health 2013b).

Rather than focusing only on producing new graduates, workforce planning must also encompass development of the existing workforce, at all career stages and qualification levels, and in all occupational roles. Again, as an outcome of the Francis Inquiry, there is now a more explicit focus on addressing the education needs of the health and care support workforce. The Cavendish review has been set up to explore how patient and service needs can be met by a workforce that has the education, support and capacity to deliver compassionate care, while there is stronger recognition of the need to facilitate career development and progression within support worker roles and into professional qualification (Chartered Society of Physiotherapy 2013b, Department of Health 2013a, 2013b and 2013d, Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013, Skills for Health 2013).

More broadly, workforce planning must embrace the imperative of career-long learning and development, both for qualified practitioners and for support workers. New approaches must demonstrate a commitment to investment in supporting continuing professional development. This has to be a focus within new workforce planning processes, including those undertaken in England by the LETBs, with sufficient recognition given to the breadth of areas in which individuals need to maintain, update and enhance their knowledge and skills. In addition to clinical leadership, example areas include health informatics and business-planning, as well as the development of advanced clinical practice skills. All contribute to service evaluation, re-design and delivery and to improving the quality and cost-effectiveness of patient care (NHS Leadership Academy 2011, Chartered Society of Physiotherapy 2013a, Department of Health 2013b, Health Education England 2013).

Implications for education

Changes in how workforce planning is implemented require a more critical approach to the workforce that is needed, the education provision required to create and sustain this workforce, and how the quality and relevance of education provision is evidenced. New approaches to workforce planning therefore carry a range of implications for education providers. Again, these form opportunities and challenges. Under increasing scrutiny is why specific professions, specific types of education programmes and specific providers should be commissioned to realise health and social care priorities in clinically and cost-effective

ways (Centre for Workforce Intelligence 2013d, Chartered Society of Physiotherapy 2013a, Department of Health 2013b, Health Education England 2013).

Challenges attached to these considerations include individual professions' education programmes demonstrating their distinctive value for service development and delivery; ensuring that the widening participation and entry to the professions agenda are genuinely pursued; and that links between education and research are maintained and nurtured (Chartered Society of Physiotherapy 2013a, Health Education England 2013). Above all, education providers need to demonstrate that their programmes equip future and current members of the workforce with the knowledge, skills and attributes to deliver safe, effective care and to lead and respond flexibly to changing priorities and service models. They need also to be able both to influence and respond to workforce planning decisions in terms of how they progress their curriculum design and delivery and demonstrate strong collaborative links with clinical service providers, service users, employers, other professions, and service commissioners and planners.

Heavily significant in this context are developments in the higher education sector - again, particularly, but not exclusively in England - that sit in parallel with those in health and social care. A culture of increased competition, within which there is a stronger focus on institutional profile and positioning (predicated on research performance, student satisfaction and employment trends, as well as on learning and teaching quality), means that the providers of education for the health and social care workforce are themselves subject to significant institution-specific and sector-wide change, and need to demonstrate the value for the profile of their institution. This has compounded the challenge of responding to rapidly changing external pressures and demands, and increased risks around maintaining stability to pursue high-quality, innovative approaches to programme development and delivery (Universities UK 2012 and 2013, Higher Education Funding Council for England 2013). This confluence of policy drives cannot be ignored when considering how health and social care education should develop, and be supported, in response to changing workforce requirements.

A fresh focus on workforce planning and education also demands a fresh consideration of practice education in terms of its relevance, sufficiency and quality. A determination to strengthen the effectiveness of workforce planning and to achieve genuinely patient-centred, compassionate care is resulting in an increasing focus on how well practice education placements prepare health and social care students for their future professional roles. At the same time, there is greater recognition of the shared responsibilities for ensuring practice education happens effectively and efficiently.

Again, there is a need to consider how practice education models can be developed: to maximise the diversity of students' placement experience (across sectors and settings); to increase the viability of placement delivery within changing, more pressured service environments (including through more lateral approaches to student supervision models that enhance opportunities for inter-professional collaboration); and to optimise the learning opportunities afforded by greater use of new technologies (including via simulated learning approaches).

A direct, emerging outcome of the Francis report recommendations is fresh scrutiny of how the quality of placement provision is assured and enhanced. Students' role in discerning and reporting where observed practice and the quality of their learning are not as strong as they should be is being highlighted (Department of Health 2013b, Health Education England 2013, Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013). Implementation of more rigorous practice - based on strong collaboration between universities and service providers, increased support for students in giving feedback on observed practice, enhanced opportunities for user involvement in shaping the quality of practice education,

and more consistently searching approaches to quality assurance and enhancement processes – will necessarily require very careful progression.

Assuring and enhancing the quality of education is therefore becoming an increasing focus (Chartered Society of Physiotherapy 2013b, Department of Health 2013b, Health Education England 2013). Within this context, measures of quality ('quality metrics') are gaining increasing currency. These include data relating to recruitment processes to programmes (with a greater, post-Francis report on 'recruiting to values') and data relating to student attrition rates and graduate employment trends (Department of Health 2013b, Unistats 2013). Inferences from such data clearly need to be made with due caution, as does the planned progression of different approaches to students' admission to health care programmes (Department of Health 2013b, Health Education England 2013).

Summary: realising workforce ambitions

New approaches to workforce planning require creative, lateral thinking if working 'back from the future' is to be successful. Predicated on changing demographics, health and social care priorities and optimising capacity to meet projected population and patient needs, such approaches must support and invest in the development of the whole workforce, at all education and career stages, and in all occupational roles, sectors and settings. Addressing this agenda is far from straightforward, with much resting on how swiftly progress can be made in tackling workforce planning differently.

However, new approaches hold out the promise of optimising how the workforce is developed to meet changing population and patient needs and to provide a lever for stronger collaboration across professions, occupational roles, sectors and settings. They also provide the opportunity to increase user involvement and input, and that of the workforce as a whole, to how services are designed and delivered. From an education perspective, there is an opportunity to strengthen the imperative for developing shared, reflective approaches to curricula development and delivery at all levels of learning, including in relation to practice education, to ensure the workforce has the skill mix, professionalism and adaptability to provide high-quality patient care in times of rapid change.

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